Birth & Death

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ 159 SB 06439

Reg. Dist. No. 354

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Worcester

City or town Stockton
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Length of mother's stay in County 4 days
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Delaware

County

City or town Wilmington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1217 W 7th St
(If RURAL give LOCATION)

3. Name of child Baby girl Allen

4. Date of birth 7/30/47 19 Hour 2.45 A M.

5. Sex Female | 6. Twin or triplet no

7. No. of weeks pregnancy 24

FATHER OF CHILD

8. Full name Robt P Allen

9. Color W 10. Age at time of this birth 34 yrs.

11. Usual occupation mechanic

MOTHER OF CHILD

12. Full maiden name Marie Isabel Colbourne

13. Color W 14. Age at time of this birth 34 yrs.

15. Usual occupation nurse, graduate

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0

(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? no During labor? no

18. Pregnancy, complications of Premature separation of placenta

19. Labor: (a) Complications of no

(b) Induced? no

20. (a) Was there an operation for delivery? no (Yes or No)

(b) State all operations, if any none

(c) Did child die before operation? no

During operation? no

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity

(b) Maternal causes Premature Separation Placenta, Retained Intrauterine Hemorrhage

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Paul Coley
(Specify if M. D., midwife, or other)

Address Snow Hill, Maryland

23. (a) No burial (Burial, cremation or removal) (b) Date thereof foetus disposed (month) (day) (year)

(c) Cemetery or crematory

24. (a) Funeral director of with after-birth.

(b) Address

25. (a) Aug 7 1947 (Date rec'd by registrar) (b) Mary M. Taylor (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

V. S. A10

Child lived 1 minute

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160a

06440

CERTIFICATE OF DEATH

Reg. Dist. No. 855

1. PLACE OF DEATH:
County Worcester
City or town Whaleyville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester
City or town Whaleyville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Beatrice Esther Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-47.

8. AGE: Years	Months	Days	If less than one day
			hrs. 1 min.

9. Birthplace Whaleyville Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Edward Williams
13. Birthplace Unknown

MOTHER 14. Maiden name Esther Davis
15. Birthplace Berlin, Md.

16. Informant Esther Davis
Address Berlin Md.

17. burial Date thereof 7-18-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Tyree
Location Germantown

18. Funeral director Anna A Burbage
Address Berlin, Md.

19. 7-18 19 47 Helen F. Hayward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18- 19 47, at 6 41 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
did not see the body, delivered by a midwife lived about one minute.	
Due to cerebral hemorrhage - Fetus history - Large head	
Due to Difficult labor.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Pt J Owens M.D. D.S.H.O.
M. D. or other
Address Greenville Anne Md Date signed July 18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06441

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:
County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Lewis Thomas Disharoon

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Bertha E. Disharoon
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 13 - 1866

8. AGE: Years: 80 | Months: 4 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Snow Hill, Worcester, Md. (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER
12. Name: Lewis Disharoon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Hales
15. Birthplace: Maryland

16. Informant: Mrs. Bertha E. Disharoon
Address: Stockton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jul 30/47 (month) (day) (year)
Cemetery or crematory: Presbyterian
Location: Stockton, Md

18. Funeral director: Wm. E. Dennis
Address: Snow Hill, Md

19. July 29 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 47 at 7 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 47, to July 27 19 47
and that I last saw him alive on July 26 19 47

	DURATION
Immediate cause of death: acute Pulmonary Edema	1 day
Due to: Hypertensive Cardiovascular Renal disease	15 yrs
Due to: Senility	
Other conditions: arthritis generalized acute Cystitis	15 yrs 2 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. La Mar, M.D. M. D. or other
Address: Snow Hill Date signed: 7/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06442

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 855

1. PLACE OF DEATH:

County Worcester

City or town Berlin R F D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin R F D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hester Elizabeth Fisher.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow.

6.(b) Name of husband or wife Mitchel Fisher.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 20, 1877.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	1	14		

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Thomas Jarvis.

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden name Ellen Wilson

MOTHER 15. Birthplace Maryland.

16. Informant Mrs. Wheatley.

Address Berlin Md R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/7/47 (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md.

18. Funeral director Bruce A. Bunting

Address Berlin Md

19. 7-7 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 July 1947, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to 4 July 1947 and that I last saw h[illegible] alive on 28 June 1947

	DURATION
Immediate cause of death Hypertension Cardio renal disease	1 year
Due to Hypertension	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

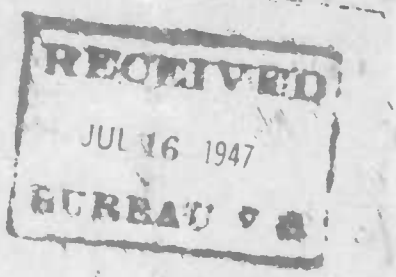
23. SIGNATURE Nathaniel T. Thomas M. D. or other

Address Ocean City, Md Date signed 7-8-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 16 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06443

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Julius Godwin

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col	married

6.(b) Name of husband or wife Fannie Godwin
6.(c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) Don't no

8. AGE: Years 66 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Accomack County (Town, county, and state)
10. Usual occupation Farm Laborer
11. Industry or business
FATHER 12. Name Don't no
13. Birthplace
MOTHER 14. Maiden name Don't no
15. Birthplace
16. Informant Sister Anderson
Address Onancock Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18-1947 (month) (day) (year)
Cemetery or crematory Onancock Cemetary
Location Suburbs of Onancock Va
18. Funeral director Henry A. Watson
Address Pocomoke City Md
19. July 18 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1947, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27th 1947, to July 13th 1947
and that I last saw h.c. alive on June 22 1947

Immediate cause of death	DURATION
Metastatic Carcinoma	2 mo
Due to Carcinoma Auricle	4 mo
Due to	
Other conditions Ch. Myocarditis	
Ch. Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. A. Whitelegg M. D. or other
Address Physician Date signed 7/16/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Name, Mary Burrier Hurley

Died, July. 25-1947. 19

Native of Maryland Widowed
Widow, ~~Married or Single~~

Sex, Female

Color, White

Age, 81

Residence, Emmorton Md.

Occupation, Housewife

Cause of Death, Cerebral Embolus

Father's Name and Nativity, John A Burrier
American.

Mother's Name and Nativity, Sarah Hall
American

W J Haynes MD Physician
July 25, 1947
Selbyville, Delaware

Interment at Mt Carmel - Emmorton Md

Undertaker, W. H. Archer

Informant, Sadie H Magness

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

838 06444

STATE BOARD OF HEALTH
DIVISION OF VITAL STATISTICS

~~DELAWARE~~ maryland.

State File No.

Registrar's No. 182

1. PLACE OF DEATH:
(a) County Worcester Hundred
(b) City or Town Fenwick Island
(c) No. Street
(If death occurred in a hospital or institution, give its NAME instead of street and number)
(d) Length of stay: In community 1 week
In hospital or institution
(Specify whether years, months, days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) Hundred, city or town Bel Air
(d) Street and No. R.F.D. #2 (if rural, give location)
(e) If foreign born, how long in U. S. A.? years

3. Social Security No. None

4. FULL NAME OF DECEASED MARY Burrier Hurley

PERSONAL AND STATISTICAL PARTICULARS

5. SEX: F

6. COLOR OR RACE: W.

7. Single, Married, Widowed or Divorced (write the word): Widowed

7a. If married, widowed, or divorced: HUSBAND of (or) WIFE of James P. Hurley

8. DATE OF BIRTH (mo. day and yr.) 1866

9. AGE: Years 80 | Months 8 | Days 26 | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

10. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. Housewife

11. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

FATHER

12. BIRTHPLACE (city or town) (State or country) Frankleinville Md

13. NAME John a Burrier

14. BIRTHPLACE (city or town) (State or Country) Penna

14a. NATIONALITY American

MOTHER

15. MAIDEN NAME Sarah Hall

16. BIRTHPLACE (city or town) (State or Country) Cecil County Md.

16a. NATIONALITY

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

17. INFORMANT (Address) Sadie Hurley Magness

Date of Information July 25-1947

18. BURIAL, ~~CREMATION OR REMOVAL~~
Place Mt. Carmel. Md. Date July 28 1947

19. UNDERTAKER W. H. Archer
Address Berlin Md

MEDICAL CERTIFICATE OF DEATH

20. DATE OF DEATH (mo. day and yr.) July 25, 1947

21. I HEREBY CERTIFY, That I attended deceased from July 25 1947, 1947 to July 25 1947

I last saw h... alive on ..., 19... Death is said to have occurred on the date stated above at 11 P. m

The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
Cerebral Embolus	7/25/47 11 P.m.
Contributory causes of importance not related to principal cause: Arteriosclerosis	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? No

22. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place
Manner of injury
Nature of injury

23. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) W Jarrett Haynes M. D.
(Address) Selbyville, Delaware

24. FILED 7/26 19 47 Vinnella Fowcock Local Sub-Registrar
FILED ... 19... Local Registrar

THIS CERTIFICATE MUST BE FILED WITH THE LOCAL REGISTRAR WITHIN 72 HOURS AFTER DEATH AND BEFORE INTERMENT OR OTHER DISPOSAL OF THE BODY

STANDARD CERTIFICATE OF DEATH

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed on account of the disease causing death, report the occupation prior to illness. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *housekeeper—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

10.—The trade, profession, or particular kind of work done.

11.—The industry or business in which the work was done.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under contributory causes of importance not related to principal cause, name other important diseases or injuries. Examples:

Example I	Date of onset	**Example II**	Date of onset
The principal cause of death and related causes of importance in order of onset were as follows:		**The principal cause of death** and related causes of importance in order of onset were as follows:	
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1924*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Contributory causes of importance not related to principal cause:		**Contributory causes** of importance not related to principal cause:	
Fracture of arm		*Influenza*	
Automobile Accident	*May 3, 1927*		*6 weeks ago*

In a group of causes containing the principal cause and related causes, the causes should be given in the order of onset, so that in a group of three causes the principal cause may appear in either first, second, or third position. The principal cause in each of the above examples happens to be the second cause given.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06445

Reg. Dist. No. 351

1. PLACE OF DEATH:

County: Worcester

City or town: Girdletree

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Girdletree

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Joseph R. Killmon

3.(b) Social Security Number: 220-10-8453

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel D. Killmon

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Dec. 22 - 1890

8. AGE:

Years	Months	Days	If less than one day
56	6	29	hrs. ... min.

9. Birthplace: La Plata Charles North Carolina (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: Fishing Bay

FATHER

12. Name: William T. Killmon

13. Birthplace: Virginia

MOTHER

14. Maiden name: Sallie Martin

15. Birthplace: Virginia

16. Informant: Mrs. Ethel D. Killmon

Address: Girdletree

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 47 (month) (day) (year)

Cemetery or crematory: Mount Hill

Location: Girdletree, Md.

18. Funeral director: Clay E. Dykes

Address: Snow Hill, Md.

19. 7/23 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947, to July 21 1947

and that I last saw him alive on July 5 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	1/2 hr.
Due to: arteriosclerosis	unknown
Due to:	
Other conditions: Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Paul Green M.D. M. D. or other

Address: Snow Hill Md. Date signed: 7/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

ITEM 14: Cer. of death of MARY ANN OLDHAM, WIFE OF FREDK. OLDHAM, on file in Balto City Health Department as of 4-15-30. Verified by phone 7-24-47 TN.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a B

06446

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County
City or town Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No. 800 S Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Nellie Oldham Knight.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Col. Alexander C. Knight
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1884

8. AGE:

Years	Months	Days	If less than one day: hrs.	min.
63	4	24		

9. Birthplace (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Oldham
13. Birthplace: England

MOTHER
14. Maiden name: MARY ANN OLDHAM
15. Birthplace: England.

16. Informant: Col. Alexander C. Knight
Address: 800 S. Washington St. Alexandria Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/7/47 (month) (day) (year)
Cemetery or crematory: DRUID Hill Cemetery
Location: Baltimore Md

18. Funeral director: Anna A. Burbage
Address: Berlin Md.

19. Jul 4 1947 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 July 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 June 1947, to 3 July 1947
and that I last saw h[illegible] alive on July 3 1947

Immediate cause of death	DURATION
Coronary occlusion	5 minutes
Due to: Coronary Sclerosis	2 years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Nathaniel K. Thomas M. D. or other
Address: Ocean City Date signed: 3 July 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06447

183

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH: County: Worcester; City or town: Ocean City (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 1 day; Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland; County: Baltimore; City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 911 Ryan St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Herman Landwehr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Hilda Landwehr. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1907

8. AGE:

Years	Months	Days	If less than one day
39	6	9	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Sheet metal worker.

11. Industry or business

FATHER 12. Name: Max Landwehr.

13. Birthplace: Germany.

MOTHER 14. Maiden name: Minnie Ebeling.

15. Birthplace: Maryland.

16. Informant: Richard Landwehr. Address: 48 Bidg. Monastery Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-14-47 (month) (day) (year)

Cemetery or crematory: Lorraine Park

Location: Baltimore, Md.

19. Funeral director: Owen A. Burbage

Address: Berlin Md.

19. 7-12-1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowning	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: July 6 47

Where did injury occur? Ocean City (City or town) Worcester (County) Md. (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other

Address: Brown Mill Res. Date signed: 7/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92b

06448

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Rural Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 wks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Accomack

City or town: Mappsville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Fred C. Mears

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Kate Savage Mears

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1881

8. AGE: Years	Months	Days	If less than one day
66	0	24	hrs. min.

9. Birthplace: Modest Town Va.

(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER

12. Name: Lloyd C. Mears

13. Birthplace: Accomack Co. Va.

MOTHER

14. Maiden name: Lou anne Littleton

15. Birthplace: Modest Town Va.

16. Informant: Mrs. Clifford M. Dryden

Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, 1947 (month) (day) (year)

Cemetery or crematory: Modest Town Cem.

Location: Modest Town, Va.

18. Funeral director: J. D. Johnson Inc.

Address: Parksley, Va.

19. July 22 1947 Annie E. White

(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1947, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 20 1947

and that I last saw h.. alive on July 1 1947

Immediate cause of death: Mitral Stenosis

Mycardial degeneration

DURATION
3 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. E. Justice M. D. or Other

Address: Pocomoke City Md. Date signed 7-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WS A15 9-425-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173 JB 06443

Reg. Diat. No. 351

1. PLACE OF DEATH:
County Worcester
City or town Rural 4 miles West of Snow Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New York County
City or town Utica
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2648 Sunset Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war World War 2

3.(a) FULL NAME: Stanley Clarence MUNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs Carolyn Howland MUNSON
6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) January 31 1921

8. AGE:	Years	Months	Days	If less than one day
	26	5	1	...hrs. ...min.

9. Birthplace Canada
(Town, county, and state)
10. Usual occupation U. S. NAVY
11. Industry or business U. S. Navy

FATHER
12. Name Alfred E. H. Munson
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Navy Health Record
Address Bureau of Medicine & Surgery Washington, D. C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 2 1947 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director Naval Hospital, Portsmouth, Va.
Address
19. 7/7 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 1015A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2 July 1947, to 2 July 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
INJURIES MULTIPLE EXTREME	
Due to AIRCRAFT CRASH	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results Not Performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7-2-47
Where did injury occur? 4 miles west of Snow Hill (City or town) MD (County) (State)
Injured at home, farm, industry, public place (where?) Rural area
Means of injury Fatal Injured at work? Yes

23. SIGNATURE S. C. Bostic
S. C. BOSTIC, Captain (MC), USN
M. D., or other
Address NAAS CHINCOTEAGUE, Va Date signed 7-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47c

CERTIFICATE OF DEATH

06450

Reg. Dist. No. 354

1. PLACE OF DEATH:

County: Worcester

City or town: Stockton Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Stockton Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Martha H. Nock

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward Nock

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15 1865

8. AGE: Years: 82 Months: 8 Days: 5 If less than one day: hrs. min.

9. Birthplace: Maryland Accomac Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: William Byrd

13. Birthplace: Virginia

MOTHER 14. Maiden name: Mary Fisher

15. Birthplace: Virginia

16. Informant: Mrs. M. Nock

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 47 (month) (day) (year)

Cemetery or crematory: Whatcoat

Location: Snow Hill, Md

18. Funeral director: Edgar E. Bunting

Address: Snow Hill, Md

19. July 21 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1947, at 10:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947, to July 20 1947, and that I last saw her alive on 7/20/47 1947

Immediate cause of death	DURATION
Carcinoma - bronchial cleft	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred L. Bonnet, M.D.
M.D. or other

Address: Salisbury, Md Date signed: 7/20/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

06451

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Jane Parker.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Henry T. Parker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 11, 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	2	26		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER — 12. Name: William H. Applebee

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Mary Elizabeth Bratten

15. Birthplace: Maryland

16. Informant: Mrs. Henry T. Parker

Address: Ocean City Md

17. (Burial, cremation, or removal. Which?) B— Date thereof 7/10/47 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Asa D. Purnell

Address: Berlin Md

19. 7-9-1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 July 1947, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946, to 7 July 1947, and that I last saw h[illegible] alive on 7 July 1947

Immediate cause of death	DURATION
Hypertensive cardio-renal disease	1 year
Due to: Hypertension - arteriosclerosis	2 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nathaniel J. Pierce M. D. or other

Address: Ocean City Date signed 8 July 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

06452

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City, R. F. D. 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City R.F. D. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Vera Purnell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: *** Fred Purnell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb, 12. 1910

8. AGE: Years	Months	Days	If less than one day
37	5	10	hrs. min.

9. Birthplace: Worcester Co, Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: ? Dennis

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Shera Brittingham

MOTHER — 15. Birthplace: Worcester Co, Maryland

16. Informant: Mervin Purnell

Address: Pocomoke City. R. F. D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/25/1947 (month) (day) (year)

Cemetery or crematory: Mt. Sinia Baptist Church Cem

Location: Wardtown. Worcester Co. Md.

18. Funeral director: Howard A. Dill

Address: Pocomoke City. Maryland

19. July 25 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1947 at 5 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to July 22 1947 and that I last saw h[illegible] alive on July 22 1947

	DURATION
Immediate cause of death: Uraemic Poisoning	5 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. E. Gaylon M. D. or other

Address: Date signed 7-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

06453

CERTIFICATE OF DEATH

Reg. Diat. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Worcester

City or town: Near Newark R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Newark R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lillie Schoolfield

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col'd.	Married

6.(b) Name of husband or wife: Julie Schoolfield

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Apprx 50			hrs. min.

9. Birthplace: Newark Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Reuben Johnson

13. Birthplace: Md.

MOTHER 14. Maiden name: Sarah E. Pennell

15. Birthplace: Md.

16. Informant: Elizabeth Johnson

Address: Newark Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/26/47 (month) (day) (year)

Cemetery or crematory: Eden Chapel

Location: Newark Md R F D.

18. Funeral director: Bruce A. Bunting

Address: Berlin Md

19. 7/26 19 47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 47, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Myocarded degeneration of heart	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John L. Riley Dep Med Exam M. D. or other

Address: Snow Hill Md Date signed 7/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

06454

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: Allegany
City or town: Wellsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME Edward Schultheis

3.(b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace E. Schultheis
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): July 27 — 1892

8. AGE: Years: 54 Months: 11 Days: 11 If less than one day: hrs. min.

9. Birthplace: New York (Town, county, and state) U.S.A.
10. Usual occupation: Produce Shipper
11. Industry or business:
12. FATHER — Name: George Schultheis
13. FATHER — Birthplace: Germany
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace:
16. Informant: Mrs Lee Schultheis
Address: 73 Park St. Wellsville, N.Y.
17. Burial, cremation, or removal: Burial Date thereof: July 12 '47 (month) (day) (year)
Cemetery or crematory: Rose Lawn
Location: Wellsville, N.Y.
16. Funeral director: Allen & Dennis
Address: Snow Hill, Md.
19. 7/8 1947 (Date rec'd by registrar) L. Day Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1947, at 8.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 AM July 8 1947, to 8.45 AM July 8 1947
and that I last saw him alive on July 8 1947

Immediate cause of death	DURATION
Cardiac failure.	2 Hr.
Due to: Acute Coronary Occlusion	2 Hr.
Due to: Hypertensive Cardiovascular Renal Disease	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar, M.D. (M. D. or other)
Address: Snow Hill Date signed: 7-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

06455

CERTIFICATE OF DEATH

Reg. Diat. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: New Church - Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County:
City or town: Phila.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2039 Wharton St
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3. (a) FULL NAME: Daniel B. Sears.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	D.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16, 1926

8. AGE: Years: 21 | Months: 10 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Norfolk Va. (Town, county, and state)
10. Usual occupation: U.S. Navy
11. Industry or business: U.S. Navy

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Alice F. Sears.
15. Birthplace: Unknown

16. Informant: U.S. Navy Health Record
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/25/47 (month) (day) (year)
Cemetery or crematory: To Naval Hospital, Portsmouth Va.
Location

18. Funeral director: N.A.G.S.
Address: Chincoteague, Va

19. 7/25 (Date rec'd by registrar) 1947 Lee Roy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1947, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Accidental drowning	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of July 24 47
Where did injury occur? Near Snowhill (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Drowning Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Examiner
M. D. or other
Address: Snow Hill Md Date signed 7/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

92

06456

Reg. Dist. No. 351

1. PLACE OF DEATH:

County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Harriett Spencer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: John Spencer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6 - 1855

8. AGE:

Years	Months	Days	If less than one day
92	3	3	..... hrs. ..... min.

9. Birthplace: Middletown Worcester Md

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: " "

MOTHER

14. Maiden name: Unknown

15. Birthplace: " "

16. Informant: Mrs Gertrude Collins

Address: Snow Hill, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 11 47 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Snow Hill Md

18. Funeral director: Elday C. Dennis

Address: Snow Hill Md

19. 7/9/47 (Date rec'd by registrar) Elday Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 19 47, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/1/47 19.. to 7/9/47 19.. and that I last saw her alive on 7/2/47 19..

Immediate cause of death	DURATION
Hypertension Myocarditis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] Chas M D

M. D. or other

Address: Snow Hill Date signed 7/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06457

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester.
City or town: Berlin RFD #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester.
City or town: Berlin.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maria Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife: James Thomas.
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1888

8. AGE: Years	Months	Days	If less than one day
58	6	21	hrs. min.

9. Birthplace: Alabama
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business
FATHER 12. Name: unknown
13. Birthplace
MOTHER 14. Maiden name: unknown
15. Birthplace
16. Informant: James Thomas
Address: Berlin Md RFD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/19/47. (month) (day) (year)
Cemetery or crematory: St Pauls.
Location: Berlin Md
18. Funeral director: Dyer & Bunting
Address: Berlin Md.
19. 7-19 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1947 at 1030 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1947 to July 17 1947 and that I last saw her alive on March 12 1947.

Immediate cause of death	DURATION
Ca advanced incapable carcinoma of rt. breast.	4½ years
Due to: —	
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. Townsend Jr. M. D. or other
Address: Ocean City, Md. Date signed: July 19, 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06458

Reg. Diat. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin Rural #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin Rural #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Joanne L. Lingle

3.(b) Social Security Number: none

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 10 - 1947
8. AGE: Years | Months: 4 | Days: 21 | If less than one day: ..... hrs. ..... min.
9. Birthplace: Berlin Worcester Md (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Otho Lingle
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mabel Purnell
15. Birthplace: Maryland
16. Informant: Mable Lingle
Address: Berlin, Md Rural #3
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31/47 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Berlin Md Rural #3
18. Funeral director: Leland E. Timmons
Address: Snow Hill Md
19. 7/31/47 (Date rec'd by registrar) R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47, at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Broncho Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other
Address: Snow Hill Md Date signed: 7/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

0645 3 350 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Worcester

City or town Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 81 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester

City or town Pocomoke city

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME (Alphonso) Adpheus Lafayette Tull

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widower

6.(b) Name of husband or wife Lorie Tull

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4 - 1866

8. AGE:

Years	Months	Days	If less than one day
81	2	9	..... hrs. ..... min.

9. Birthplace Pocomoke City Worcester Co Md (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER

12. Name Parker Tull

13. Birthplace Pocomoke City Worcester

MOTHER

14. Maiden name Hannes Pittingham

15. Birthplace New church Accomac Co

16. Informant Adolpheus Tull

Address R2D3 Box67 Pocomoke city Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1947 (month) (day) (year)

Cemetery or crematory Hall's Hill

Location Pocomoke City Md.

18. Funeral director Charles H Ward

Address Marion Md.

19. July 15 1947 (Date rec'd by registrar) Anne E White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13- 1947, at 4-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4th 1947, to July 13 1947

and that I last saw h... alive on July 12th 1947

	DURATION
Immediate cause of death C. myocarditis	2d
Due to	
Due to	
Other conditions C. Arthritis	Several Yrs

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

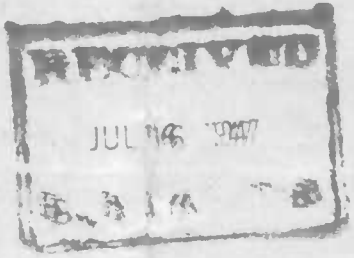
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D E Tarrant M. D. or other

Address Pocomoke City Md Date signed 7/15/47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JUL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94E

CERTIFICATE OF DEATH

06460

Reg. Diat. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Rural, Pocomoke, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural Pocomoke, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Harold T. Wilkerson

3.(b) Social Security Number 216-12-1749

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Bertie Wilkerson
6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 10, 1892

8. AGE: Years	Months	Days	If less than one day
55	3	0	...hrs. ...min.

9. Birthplace Sanford, Accomack Va.
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business —

FATHER
12. Name Noah T. Wilkerson
13. Birthplace Virginia

MOTHER
14. Maiden name Dora Wilkerson
15. Birthplace Virginia

16. Informant Mrs Bertie Wilkerson
Address Rural Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13, 1947 (month) (day) (year)
Cemetery or crematory Miles Cemetery
Location Sanford Virginia

18. Funeral director Henry A. Watson
Address Pocomoke Md.

19. July 12, 1947 (Date rec'd by registrar) Anne E. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 10 1947
and that I last saw h... alive on July 10 1947

	DURATION
Immediate cause of death Virginia Failure	3
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE C. E. Fuller M. D. or other
Address Pocomoke City Md. Date signed 7-11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING